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NOTES

THE SHANAY JOHNSON INQUEST JURY'S RECOMMENDATIONS FOR CHILD WELFARE

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On May 9, 1997, the jury serving on the Chief Coroner's inquest into the death of 22 month-old Shanay Johnson made 107 recommendations on how to improve child welfare and protection in Ontario.[1] These recommendations touched on criminal law, court procedures, provincial legislation, child welfare and protection, administrative practice, and the relationship between Children's Aid Societies (CASs) and Ontario's Ministry of Community and Social Services. This note summarizes the recommendations made by the Jury.

The Jury recommended that the federal government amend the Criminal Code to include the offense of Death by Child Abuse/Neglect which would not require the specific intent to kill. Anyone found guilty of this crime, the equivalent of second degree murder, would face a minimum term of imprisonment without eligibility for parole.

According to the Jury's report, the fundamental purpose of the Family Court system should be "to promote the best interest and protection of children"(p. 5). To this end, the Jury recommended that a Judicial Case Management System be created to allow Court personnel to follow individual cases through the system over time. The Jury also recommended that Family Courts be given additional authority to structure parents' relationship with children found to be neglected or abused.

With respect to the government of Ontario, the Jury recommended that children's rights be spelled out clearly and explicitly in all provincial legislation affecting children. The Jury also recommended that the province issue a statement that children's interests are a "paramount priority" and that this commitment inform all decisions affecting children's services funding, legislation and policy. Additional funding for such things as day care, children's mental health centres, drug abuse programs, parent education and home care was also recommended.

The Jury made a number of recommendations concerning the Ministry of Community and Social Services (MCSS) to "ensure a clearer focus on the child protection system and the provision of leadership and support to that system"(p. 7). These recommendations included:

- appointing a Director of Child Welfare and Protection;
- conducting a mandatory review of all children's deaths;
- developing a comprehensive risk assessment tool across the child welfare sector;

[1] Ontario. Ministry of the Solicitor General, Office of the Chief Coroner, *Verdict of the Coroner's Jury on the Inquest into the Death of Shanay Jami Johnson* (Toronto: The Chief Coroner, May 1997).

- creating standards on caseloads for children's aid workers;
- creating a provincial database of child-welfare cases accessable to all CAS workers; and
- developing child-neglect issue training for doctors, lawyers, judges, nurses and other professionals.

The Jury also recommended that MCSS amend Ontario's *Child and Family Services Act* to:

- increase supervision of children given back to their families after having been in care;
- amend case confidentiality rules so child-protection workers and the medical profession can share information;
- expand the definition of "children in need of protection" to include those families who have alcohol or drug abuse problems or prior incidents of neglect;
- require child welfare and protection professionals to report even a suspicion of child neglect;
- make it an offense for adults with knowledge of a neglectful situation to fail to report that situation (expanding the current reporting requirements for specified professionals); and
- ensure that children younger than 3 years of age not be kept in temporary custody for more than two years without consideration of a permanent care plan such as adoption or return to the parent.

With respect to Children's Aid Societies, the Jury recommended that CASs:

- create and implement a comprehensive assessment and planning model which includes an eligibility tool, a safety assessment and risk assessment tool, and an instrument for assessing parental capacity;
- provide better training to case workers on all available assessment tools, in conjunction with MCSS;
- conduct more unannounced home visits in moderate- to high-risk cases;
- have supervisors conduct more individual case and case worker reviews, including regular performance appraisals; and
- adopt a more comprehensive record-keeping system.

The final group of recommendations were directed at health care professionals. Most dealt with the dissemination of information about forms of child maltreatment, health care professionals' legal and ethical responsibilities in cases of child maltreatment, and training on assessment and investigation of neglect.

The Jury's final recommendation was that the Chief Coroner convene a press conference in May 1998 to update the status of the recommendations.

Janet Ecker, Minister of Community and Social Services, has stated that the Ministry will review the recommendations.[2] But while the province plans to hire more public health nurses to screen newborns and identify high-risk children and families, Ecker rejected the Jury's recommendation to appoint a Director of Child Welfare and Protection, claiming that "simply appointing another bureaucrat is not the answer."[3]

[2] Dale Anne Freed, "Stiffer laws urged as Shanay's legacy," *Toronto Star*, 10 May 1997, p. A1.
[3] Ibid.

ISSN 1206-1360